



ELSEVIER

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research report

The exacerbating influence of hopelessness on other known risk factors for repeat self-harm and suicide

Sarah Steeg^{a,*}, Matthew Haigh^b, Roger T. Webb^a, Nav Kapur^a, Yvonne Awenat^c, Patricia Gooding^c, Daniel Pratt^c, Jayne Cooper^a^a Centre for Suicide Prevention, University of Manchester, United Kingdom^b Department of Psychology, Northumbria University Newcastle, United Kingdom^c School of Psychological Sciences, University of Manchester, United Kingdom

ARTICLE INFO

Article history:

Received 6 July 2015

Received in revised form

6 September 2015

Accepted 26 September 2015

Available online 28 October 2015

Keywords:

Hopelessness

Self-harm

Suicide

Epidemiology

Psychosocial assessment

ABSTRACT

Background: Hopelessness is frequently observed in people who harm themselves and is an established risk factor for nonfatal self-harm repetition and suicide. Little is known about how the presence of hopelessness in addition to other risk factors affects subsequent risk.

Method: Prospective cohort of 19,479 individuals presenting with self-harm to one of three English Emergency Departments between 1st January 2000 and 31st December 2010. Repeat self-harm and suicide deaths within twelve months of the first assessed episode were identified. Cox Proportional Hazards models were used to estimate Hazard Ratios (HRs) for risk factors with and without hopelessness.

Results: A clinical impression of hopelessness was associated with increased risk of further self-harm (HR 1.35, 95% CI 1.16–1.58) and suicide (HR 2.56, CI 1.10–5.96) in the year following an index episode. For individuals who were living alone or homeless, unemployed, reported problems with housing, had received psychiatric treatment in the past, were currently receiving treatment or used alcohol during the self-harm episode, an exacerbation of an already elevated risk of repetition was observed amongst those who were assessed as hopeless. Where individuals presented with forensic problems, physical health problems or bereavement, an increase in risk was only observed for those who were also assessed as hopeless.

Limitations: A clinical impression of hopelessness was assigned using a binary “yes”/“no” classification rather than a validated scale.

Conclusions: Hopelessness intensifies the impact of several known risk factors for adverse outcomes following self-harm. These findings highlight the importance of identifying and therapeutically addressing this dynamic but potentially modifiable clinical risk factor during the psychosocial assessment and in subsequent care.

© 2015 Elsevier B.V. All rights reserved.

1. Introduction

Large-scale epidemiological studies have provided information about factors associated with the repetition of suicidal behaviour, largely identifying fixed and non-modifiable characteristics. Clinical guidance for the United Kingdom produced by the National Institute for Health and Care Excellence (NICE, 2011) reviewed evidence from prospective cohort studies to bring together population-level risk factors for repeat self-harm and suicide. Nine key risk factors were identified: a history of self-harm, depressive

symptoms, a history of psychiatric treatment, alcohol misuse, physical health problems, gender (male gender for suicide risk and female gender for risk of repeat self-harm), marital status and level of suicide intent. A report by the World Health Organisation (2014) summarised key risk factors for suicide including isolation, relationship conflict or loss, previous suicide attempt, mental disorder, harmful use of alcohol, loss of employment, financial problems, hopelessness, chronic pain, family history of suicide and genetic and biological factors, as well as influences from a wider systemic level such as access to means and the availability of appropriate health care. The report emphasised that vulnerability to suicide is likely to result from the cumulative effect of a number of risk factors.

Hopelessness has featured strongly in psychological theories of suicide. Initially the term was used broadly, to describe generalised

* Correspondence to: Centre for Suicide Prevention, University of Manchester, Jean McFarlane Building, Manchester M13 9PL, United Kingdom. Tel.: +44 161 275 0718.

E-mail address: sarah.steeg@manchester.ac.uk (S. Steeg).

negative expectancies about the future and feelings of depression (Menninger, 1938). Later, in an attempt to quantify “hopelessness”, a scale was derived and validated. Beck’s “Hopelessness Scale” (Beck et al., 1974) is made up of 20 specific measures and incorporates themes including “Feelings About the Future”, “Loss of Motivation” and “Future Expectations”. Theories about the relationship between hopelessness and suicide have also been refined. Menninger, in 1938, identified hopelessness, in its broad sense, as a fundamental dimension of suicide (Menninger, 1938). Beck went on to find that suicidal intent was more correlated with hopelessness than with depression (Beck et al., 1974). More recent models of suicidal behaviour, for example the “Cry of Pain” model (Williams and Pollock, 2000) and the Schematic Appraisal Model of Suicide (Johnson et al., 2008) emphasise the role of hopelessness in the development of suicidal behaviour. For example, the “Cry of Pain” model includes a specific prediction that feelings of defeat can lead to feelings of entrapment, which, when projected into the future, can lead to hopelessness. Another recent model of suicidal behaviour focusses on the development of suicidal act from suicidal ideation, taking into account components increasing risk at each stage, including those relating to positive future thinking (O’Connor, 2011). A recent review highlighted hopelessness as one of the key psychological risk factors for suicidal ideation and behaviour (O’Connor and Nock, 2014). Feelings of hopelessness have been found to be associated with initiation of self-harm (Milnes et al., 2002), risk of repeat self-harm (McMillan et al., 2007) and suicide (Beck et al., 1990). In a recent international review of case-control and cohort studies, hopelessness was found to be associated with a greater than twofold increase in risk of suicide amongst people with depression (Hawton et al., 2013). However, prospective, hospital-based studies of self-harm have tended to examine risk factors in isolation, overlooking their cumulative effect (Larkin et al., 2014). Their inclusion could enhance understanding of some existing known risk factors (Kessler et al., 1999; Larkin et al., 2014).

The goal of the current study was to address this gap with a focus on the psychological variable hopelessness. We aimed to examine how a clinical impression of hopelessness, identified in individuals attending the Emergency Department (ED) following self-harm, augments risks of repeat self-harm and suicide in individuals with other known epidemiological risk factors. Our specific objective was to examine the additive effect of hopelessness on twelve-month risk of repeat self-harm and suicide in the presence of known risk factors for repetition, using data available from a prospective cohort of self-harm patients described below.

2. Method

2.1. Study design and setting

A prospective cohort study identified all cases of self-harm by individuals aged 16 years and over attending three Emergency Departments (EDs) in the City of Manchester, England. We defined acts of self-harm as those that involve “intentional self-injury or self-poisoning, irrespective of motivation” (Hawton et al., 2003), in line with definitions commonly used in clinical record-based (Bergen et al., 2010; Kwok et al., 2014) and Medicaid claims-based (Olfson et al., 2013) studies of self-harm. Hospital records and medical notes were systematically searched to identify all ED presentations involving self-harm, providing information on age, gender, method of self-harm and date of presentation for all individuals presenting to any of the three study hospitals, regardless of the treating they received upon presentation to hospital. Other identifying information such as NHS number and date of

birth was also recorded, allowing individuals to be monitored for future attendances. In addition, most patients received a psychosocial assessment, either by an ED clinician or a mental health specialist (or both), upon presentation to hospital allowing the collection of more detailed contextual data and patients’ mental state and social circumstances.

2.2. Measures

We focused on individuals who received at least one psychosocial assessment during the study period. Assessments were conducted by ED clinicians upon presentation to hospital or by mental health specialists, the majority of whom were a mental health nurse or psychiatrist, following referral from the ED. Assessments carried out by ED clinicians comprised a brief proforma assessment, which can be found, along with a more detailed description of the methodology and study population characteristics, in a previous report (Bickley et al., 2013). A psychosocial assessment carried out by a mental health specialist refers to “a comprehensive assessment including an evaluation of needs and risk.”... “designed to identify those personal psychological and environmental (social) factors that might explain an act of self-harm” (NICE, 2011). Where a patient received both assessments, information about hopelessness was obtained from the assessment conducted by a mental health specialist, as it was likely that this was the more in-depth assessment. Patients’ first assessed episode during the study period was used as the index episode, regardless of assessor type. As part of both assessments, a clinical impression of hopelessness was assigned by the ED/mental health clinician, using a binary “yes” or “no” classification on a standardised pro-forma. The clinicians were asked to give a clinical impression of hopelessness based on the patient’s current mental state. No standard prompt or definition was provided. Other established risk factors were selected for analysis if they were routinely recorded as part of the psychosocial assessment or were contained within the hospital records. Thus, the following variables were identified as relevant to this study: self-harm within the past year, living alone or homelessness, cutting as a method of self-harm (for the episode being assessed), current or previous treatment for a psychiatric disorder, unemployment, use of alcohol at the time of the self-harm, gender and problems with relationships, work, money, housing, forensic problems (such as an impending court case), poor physical health or bereavement.

Repetition was identified if an individual returned to a study hospital with self-harm within twelve months of the index episode. The cohort was linked with national records (DLS; Health and Social Care Information Centre, 2013) to identify any subsequent suicides up until 31st December 2012. We included deaths assigned verdicts of suicide (ICD codes X60–X84) and undetermined cause (Y10–Y34, excluding Y33.9) (World Health Organization, 2010).

Approval from the National Information Governance Board for Health and Social Care (NIGB) under Section 251 of the NHS Act 2006 was obtained to collect data from EDs and to link these data with mortality information.

2.3. Statistical analyses

Analyses were conducted using Cox Proportional Hazards models based on information gathered from an individual’s first assessed episode of self-harm within the study period. The number of days between the index episode and an event (self-harm repetition or suicide) was calculated for each individual. The first hospital presentation in the study period where an assessment took place was defined as the index episode from which survival time was calculated. Where there was no event within twelve

Download English Version:

<https://daneshyari.com/en/article/6230778>

Download Persian Version:

<https://daneshyari.com/article/6230778>

[Daneshyari.com](https://daneshyari.com)